

# Improving Population Health in Rural Communities: C-Suite Skills for the New Delivery Systems...Continued



Washington State Hospital Association  
Rural Health Systems

September 24, 2014



CPAs & BUSINESS ADVISORS

[www.eidebailly.com](http://www.eidebailly.com)



# Concepts Covered in September 12<sup>th</sup> Webinar

- Why a new model is needed
  - Uncontrolled costs
  - Health reform implications
- Migration from just medical care delivery to include health care under population health concepts
- Population health demands new skills and delivery models
- Care delivery IS and WILL BE a TEAM sport; challenge will be to include physicians in the effort
- Adaptive challenges physicians face
- The physician engagement framework
- Two strategic paths to population health
- Tomorrow's Health Systems: 10 Characteristics for Success



# 10 Disruptive Forces in Health Care

	Disruptive Force	Brief Implication of the Force
1	Transition to value-based reimbursement: More affordable, higher quality care at lower reimbursement rates	<ul style="list-style-type: none"><li>• Hospital Systems are now health care systems that also provide wellness and pre-emptive care, rather than merely <i>sick</i> acute care, which necessitates population health management methods, processes and protocols</li></ul>
2	Shifting volumes and lower reimbursements	<ul style="list-style-type: none"><li>• Most systems will need to reduce costs by 20 - 40% while acting to maximize and creatively optimize the reconstituted utilization of all systems.</li></ul>
3	Moving from caring for sick individuals to managing the health of a population	<ul style="list-style-type: none"><li>• Ambiguity is high with defined parameters for care and reimbursement still being developed.</li><li>• The law focuses on prevention and primary care to help people stay healthy and to manage chronic medical conditions before they become more complex and costly to treat.</li></ul>
4	Advances in health information technology	<ul style="list-style-type: none"><li>• Electronic health records allow for clinical integration and fill optimization requires developing analytics that leverage and optimize big data.</li></ul>
5	Acceleration in introduction of digital health tools, advanced medical technology and medical models	<ul style="list-style-type: none"><li>• Telemedicine and personalized medicine will become (are becoming) accepted models of care likely driving higher levels of patient engagement in their own health management.</li><li>• Diagnosis and treatment is preventative, image based and, therefore, less invasive.</li></ul>

Source: *10 Disruptive Forces in Healthcare*, beckerhospitalreview.com, May 12, 2014



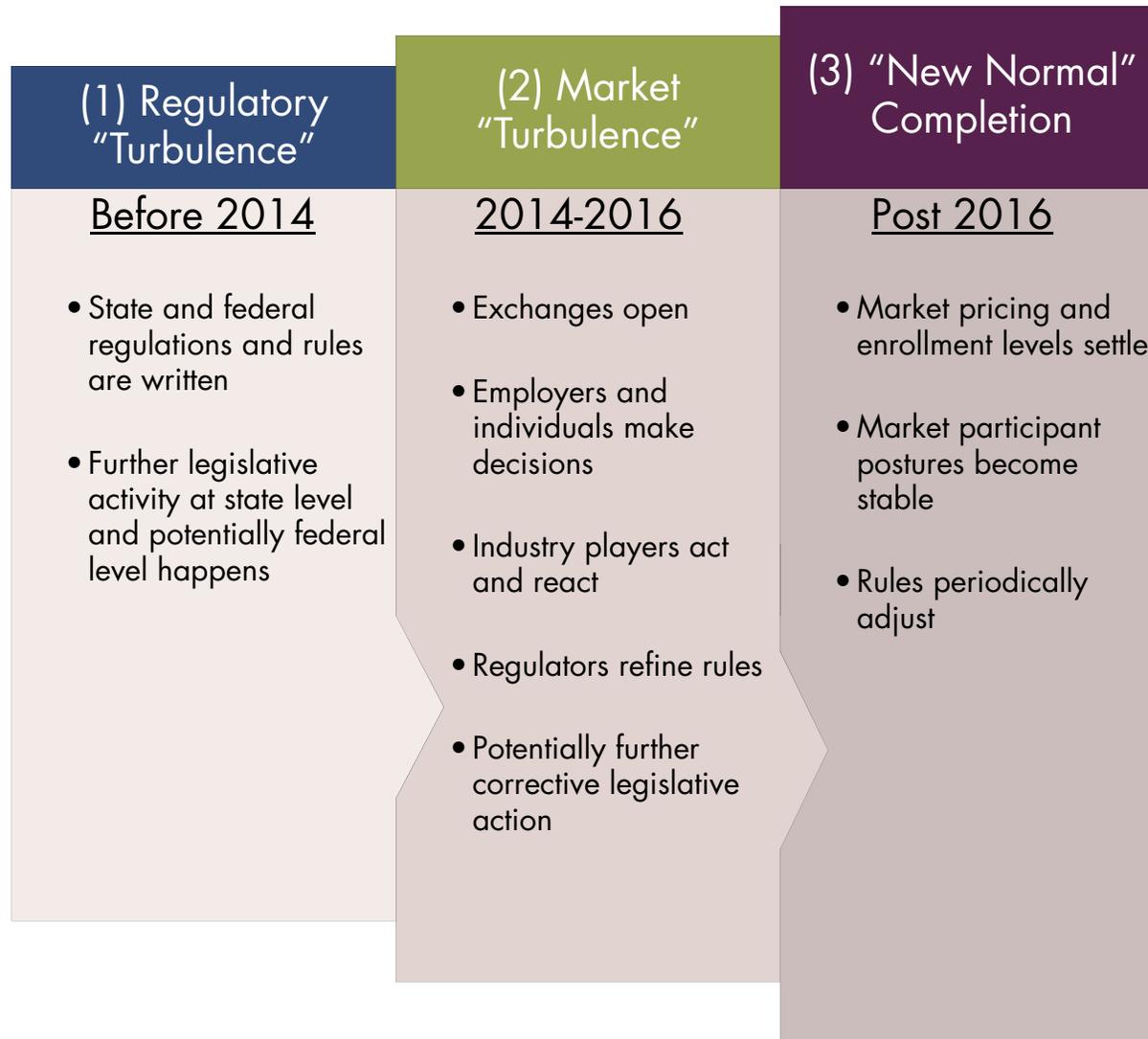
# 10 Disruptive Forces in Health Care (cont.)

	<b>Disruptive Force</b>	<b>Brief Implication of the Force</b>
6	Shifting demographics; Older, more diverse, larger income disparities, greater access	<ul style="list-style-type: none"><li>• Providers need to be able to provide the appropriate care in the patient's cultural context and offer a wide range of health needs based on segments.</li></ul>
7	Projected provider shortages	<ul style="list-style-type: none"><li>• Creating the proper match between the necessary type of care needed per each specific case and the provider best suited to provide it as evolving care shifts from more care being delivered by care providers other than physicians.</li></ul>
8	Informed and involved patients	<ul style="list-style-type: none"><li>• Providers must be able to support patients in adhering to care plans, especially as an increasing number of patients are cared for in post-acute settings and have greater access to varied medical opinions, patient consensus on best practices and efficiency metrics through increased use of the internet.</li></ul>
9	Increasing government regulation	<ul style="list-style-type: none"><li>• Deteriorating trust between bio-pharmaceutical companies, device manufacturers and the FDA results in slower, more complex approval processes while the FDA considers regulating health care IT systems, thereby increasing its involvement in care delivery.</li></ul>
10	Shrinking availability of capital	<ul style="list-style-type: none"><li>• Perceived unpredictability of government regulation dampens investment in medical technology and care providers, while financial difficulties limit debt capacity for many hospitals.</li></ul>

Source: *10 Disruptive Forces in Healthcare*, beckerhospitalreview.com, May 12, 2014



# Reform Driven Industry Shifts Will Occur Over 3 Distinct Phases





# What Do Patients Want from the Health Care Delivery Team

- Respect followed by **service** given in a high quality, very safe manner.
- Patients expect that the **information gap** will be **closed**.
- **Convenience** including rapid appointments, short waiting times and short driving distances.
- Want and expect (even though it may not be paid for by insurance) **good communication** including use of email or text messages.
- Three important ways that patients are **cared** for:
  - The use of multi-disciplinary teams coordinated by a PCP to treat patients with chronic illness
  - Immediate transfer of patients with acute life threatening illnesses like strokes and myocardial infarcts
  - Patient self referral to specialty centers for treatment of complex chronic illnesses like cancer or multiple sclerosis.

# »»» Emerging Clinicians

- Trained to service a profession, not a business model
- Dedicated to 1:1 patient care, aggregated to a certain “panel” size (e.g., 2,200-2,500 patients per year, +/- three visits per patient, for a typical family medicine physician)
- Individually struggling with professional/personal life balance issues but increasingly compromising compensation upside for satisfactory balance
- Struggling to meld operational “one best way” into own personal clinical practice style; for primary care, personal efficiency is the operating mantra under the 1:1 nurse ratio model: the Medical Home is challenging this existing model.



# Emerging Clinicians

- Above all else, pursuing security within one's own life balance definition (personal/professional)
- Willing to accept per unit market pay but struggling with requisite (volume-based) market effort (especially if the above-defined balance results in less than a 1.0 FTE professional position)
- Validating their personal balance choices by the personal economic ROI report card (not such business concepts as growth in market share, access points, extended service line capabilities, ancillary modalities, etc.)
- Waning business entrepreneurship and profitability because of past medical school selection processes and continuing per unit reduction in third-party payments for clinical efforts



# Why Physicians and Management Struggle to Coexist

Differences		
Physicians	Managers	Steps to Narrow and Differences
Doers	Designers	Acknowledge the sense of pain and loss among health care professionals without blame or trivialization
1 on 1 problem solving	1 on many problem solving	Confront unrealistic expectations and assumptions
Reactive	Proactive, with long time spans before results	Confront anxieties and fears of the unknown
Immediate response	Long-term response	Express recognition, support and caring
Deciders	Delegators	Take time to develop trust
Autonomous	Collaborators	Seek clarification from conflict

Source: Physician Executive



# Why Physicians and Management Struggle to Coexist (cont.)

Differences		
Physicians	Managers	Steps to Narrow and Differences
Independent	Participative	Re-create the romance through shared visions and hope
Patient advocates	Organizational advocates	Focus on goals, not means
Professional identity	Organizational identity	Focus on the future
Independent professionals	Interdependent professionals	Celebrate through testimonials
		Make effective communication a top priority
		Have the courage to make adjustments to a changing environment



# Transitions in Medical Group Structures

One "Group of Practices"	One "Group Practice"	Integrated Delivery System
Individual freedom of expression	Individuals begin to give up degrees of individuality and accept higher degrees of organizational control; security plus economies of scale	Wholistic orientation; clinical task interdependence and the highest levels of team work are valued, not viewed as necessary evils
Personal interests prevail (not collective)	Increasing degrees of task interdependence is accepted	Individual members actively seek and thrive on challenge, autonomy, change, and innovation
Participation <b>"As long as I get what I want"</b>	Organization is designed to outlive any individual member	The organization's value to customers/clients/patients is most important; personal satisfaction results when above are done well

Adapted from: Rubin, PhD, Irwin. "Organizations Have to Grow Up." Physician Executive



# Transitions in Medical Group Structures (cont.)

One "Group of Practices"	One "Group Practice"	Integrated Delivery Systems
Performance standards are only broad standards of patient care	Decision-making protocols are formalized	Decisions have consequences that are carried out
Short range income issues consume group's attention	Mission - survival and attainment of short-term quantitative results	Set the "standard" for the industry is the mission; proactive not reactive to the environment
Physician time for managerial responsibility is given token financial support and even less emotional support	A formal reward/recognition system is installed	Everyone has "customers"; feedback is sought and acted on, resulting in further individual and organizational development



# Transitions in Medical Group Structures (cont.)

One "Group of Practices"	One "Group Practice"	Integrated Delivery System
Satisfies lower order human needs, such as safety/security, shelter, etc.	Satisfies mid-level needs for security and self-esteem	Maslow's highest-order needs for self-actualization are met
Low tolerance for delayed gratification and conflict avoidance is the norm	Avoiding conflicts is no longer the dominant model, resolving conflicts is	Preventing conflicts is the norm; outcome, purpose, processes are well thought through – in advance
We-they positioning occurs, such as <ul style="list-style-type: none"><li>• Physicians ↔ Administrators</li><li>• Primary care members ↔ Procedural members</li><li>• Young ↔ Old</li></ul>	Loose informal relationships are replaced by formalized role descriptions with written performance expectations	Individuals seek to live: <ul style="list-style-type: none"><li>• golden rule...</li><li>• empathy...</li><li>• honest ... AND... integrity</li><li>• servant leadership</li></ul>



# Physician Alignment Continuum

## (STRUCTURE/PROCESSES)

	<b>Admitting Privileges</b>	<b>Recruitment</b>	<b>ER Coverage</b>	<b>Clinical Oversight</b>	<b>Contracting</b>	<b>Employment</b>
↓ <b>I N C R E A S I N G</b> <b>C O M P L E X I T Y</b> ↓	Hospitals extend admitting privileges to physicians interested in admitting patients to hospital	Physicians Recruit their own replacements or additions without the hospital involvement	Physicians provider ER coverage at no expense to the hospital	Physicians serve as medical director for various areas of the hospital such as lab, SNF, HHA, etc. at no cost to hospital	Hospital begins contracting with physicians to provide services to the hospital patients outside of just ER such as e.g. surgery, radiology, pathology	Hospital employee physician in primary care physicians and selected specialists, clinic operations become financial responsibility of the hospital. Physicians are compensated at FMV
	Physicians admit patients to the hospital at no charge to the hospital	Physicians receive financial support from hospital for recruitment expense	Physicians provide ER coverage of hospital for an hourly or daily rate from hospital for just weekends but still provide weekdays at no cost	Physicians serve as medical director under agreement with the hospital for specific areas and duties and the hospital pays the physicians a FMV hourly rate for documented activity	Hospital begin contracting with certain types of physicians such as surgical specialists that are difficult to recruit within community, without financial support from the hospital	
		Physicians receive financial support from hospital for recruitment expenses and for income guarantees	Physicians provider ER coverage and hospital pays for all hours and days	Physician serves as co-manager with department head over specific service line with specific documented duties for each role and hospital compensates physician at FMV hourly rate or agreed upon salary or contract amount	Hospital begins contracting primary care physicians in lieu of providing financial guarantees to private clinics	
		Physicians receive financial support from hospital for recruitment expenses and for income guarantees for new physicians and impact on existing physicians	Hospital begins to hire locums or full time ER physicians to reduce call requirements on local physicians	Physician is sole head of department with documented duties and hospital compensated physician at FMV hourly rate or agreed upon salary or contract amount	Hospital contracts with local primary physicians through PSA or independent contractor models, clinic operations become financial responsibility of the hospital. Physicians are compensated at FMV	
		Physicians and Hospitals work together to develop a medical staff development plan for the future of the community	Hospital covers all ER coverage without local physician 24/7/365		Hospital begins contracting with hospitalists to cover all inpatients, initially during the week then full time 24/7/365	



# Summary: Field Guide to Physician Alignment

	Independent Medical Staff	Physician Hospital Organization	Management Services Organization	Co-Management	Integrated Salary Employment
<b>Description</b>	Traditional arrangement in which community physicians are granted privileges	Independent entity of hospital and physicians to contract with payers	Entity that provides a range of management services to physicians	Contract for physicians to manage a particular service line for a hospital	Hospital directly employs physicians – all or some of medical staff
<b>Strengths</b>	Market provides physician productivity incentives	Access to new payers; improved market leverage; little capital required	Improves physician economics without acquisition or employment	Can improve quality and efficiency; may protect share, reduce physician defections	Protection from private practice risks; latitude in hospital expansion and recruitment
<b>Weaknesses</b>	Referral streams can be fragile; no formal alignment or controls related to UR, cost, etc.	Often doesn't yield physician loyalty; can include poor performing physicians	Uncertain physician alignment/loyalty; historically delivered low value	Busiest, highest revenue physicians likely not interested; moderate legal cost vs. higher legal risk	Can be very expensive; tendency to employ "poor performers"
<b>Applicability</b>	Most U.S. hospitals	Areas of physician surplus, small practices, and/or high managed care	Two hospital markets where one is employing physicians; high physician-payer tension	Hospitals with potential physician competitors who are risk averse and/or who desire "control" vs. income	Rural and indigent areas; markets with small practices; very competitive markets
<b>Examples</b>	Outsourced coverage contracts, diagnosis-specific clinic	Next-Generation PHO	Revenue-Oriented MSO	Volume-Indexed co-management; tandem service line management	Staff model; Temp-to-Hire arrangement

Source: Health Care Advisory Board



# Physician/Hospital Alignment: Key Trends

- Historical alignment – overview
  - Hospital – acquire new market share
  - Physician – income security and growth working capital and career stability
- The current physician perspective
  - Security for career and monetary gain, subject to fair market value parameters
  - Larger medical groups are not rushing to hospital employment, but rather seek clinical integration structures under “systems of care”
  - Institutional investors become a viable capital partner for larger groups, Max Reiboldt, CPA



# Physician/Hospital Alignment: Key Trends

- Many health systems have completed Stage I – organizational alignment ... now moving to Stage II – ACA driven clinical integration through ACOs and CINs
- Compensation designs are including care management, enhance quality, and cost control metrics (in addition to traditional professional volume incentives)
- Governance/leadership structures are moving toward DYAD model (lead MD/DO and Adm); function like partners, not adversaries
- Hospital – hospital consolidations will continue; smaller entities will be re-purposed
- Payers are becoming investors in physician practice
- Clinically integrated networks (CIN) (e.g., ACOs)
- Greater interest in consolidations: size matters
- The current hospital perspective
  - Integrated delivery system development will continue; more “economic partnering”
  - A pluralistic approach to alignment to include PSAs, co-management, clinically integrated networks, etc.



# Physician/Hospital Alignment: Key Trends

## • The Future ... 2014

- PPACA will have extensions and implementation changes as politics continue to play out
- Clinical care integration (Stage II above) will become the alignment “norm”
- Physician pay plans will continue to move from “fee for volume” to “fee for value”
- Measuring value outcomes for care delivery processes will increase with fee bundling, shared savings, and capitation reimbursement changes

## • Summary

- Industry evolution will focus on **physician/hospital alignment** and **clinical integration**



# Five Key Elements Driving Physician Engagement

- Engagement in their work is a key driver of physicians' satisfaction or dissatisfaction with their jobs, and a new survey shows how physicians define that "engagement".
- Physician engagement has become increasingly urgent for health care organizations, yet it is a term that is too broad to be meaningful," Michel Best, Physician Wellness Services CEO, said in a news release for the survey, from Physician Wellness Services and Cejka Search.
- According to the survey, physicians feel the following **five elements** are the most important when it comes to their engagement:
  1. Respect for my competency and skills
  2. Feeling that my opinions and ideas are valued
  3. Good relationships with my physician colleagues
  4. Good work/life balance
  5. A voice in how my time is structured and used

Note: Survey data was collected in September 2013 and includes responses from 1,666 physicians from across the country.



# Five Ways for Hospitals to Get Physicians More Engaged

Five areas physicians ranked as the most important to being engaged with their organization

**1. Respect** for their competency and skills.

- There needs to be an opportunity for physicians to lead and participate in organizational initiatives.
- Hospitals should also provide career or skill growth opportunities to their physicians.

**2. Feeling** their opinions and ideas are **valued**.

- The closer administrators can get to the physician, the better communication works.
- Attend department meetings, when possible.
- Stop by an individual physician's office to ask for his or her opinion one-on-one

**3. Good relationships** with physician colleagues.

- Providing opportunities for gatherings outside of work. Sending a group of physicians to conferences on the delivery of care is one way to do this.
- Hospitals can also offer conflict management programs geared specifically toward physicians.

**4. Good work/life balance**.

- One common way hospitals can promote a good work/life balance is by using a hospitalist model.
- There are other steps hospitals can take to improve the balance of its physicians' lives.

**5. A say** in how **their time** is structured and used.

- Physicians know how much time they need with patients.
- Some problems won't wait and some can be handled more expeditiously.
- Time with patients is a very personal issue with physicians so this is one key area to let them take the lead.

Source: *5 Ways for Hospitals to Get Physicians More Engaged* by Heather Punke  
BeckersHospitalReview.com, February 6, 2014



# Nine Steps Toward Greater Physician Engagement

## **1. Communicate, Communicate, Communicate.**

Communication is the central component of physician engagement. Hospitals and health systems should develop a communication plan to consistently deliver information to their medical staff. Senior leadership should be visible and meet regularly with physicians both formally and informally- to listen to their concerns and share important organizational developments.

## **2. Enhance Board Involvement.**

Physicians need a voice in the boardroom beyond the placement of a physician in a formal board position. The board should dedicate time to talk about physician issues, and board members should be present at important medical staff meetings.

## **3. Take Action.**

It's important to respond to physicians' concerns and suggestions in a timely manner. Senior leaders need to deliver on promises to establish trust with the medical staff.

## **4. Seek Input.**

Physicians should have a voice in the decision-making process for all important organizational decisions, including strategic and capital planning. Involving physicians in the decision-making process creates a partnership and shared vision between the medical staff and hospital leadership.



# Nine Steps Toward Greater Physician Engagement

## **5. Support Physician Leadership Development.**

Educational programs that address physician leadership are essential. It's important to have processes in place to identify potential physician leaders. Areas of development may include health care economics, change management and team-building.

## **6. Enhance Physician Productivity.**

Demonstrate value by recognizing the importance of physicians' time. Adopt practices and technologies to streamline patient care and enhance productivity.

## **7. Hire for Fit.**

Use behavior-based hiring tactics that will ensure that new hires are a good cultural fit for the organization.

## **8. Set Expectations and Accountability.**

Set clear behavioral and performance expectations with the medical staff and hold them accountable for results. Poorly performing physicians can bring down morale. Align compensation with performance measures.

## **9. Recognize and Reward Accomplishments.**

It's important to reward and recognize physicians for their accomplishments beyond compensation. Write thank-you notes to physicians for exceptional performance in outcomes, patient engagement and participation in performance improvement initiatives.



# Aligned Partners

## Top 10 Characteristics

1. Attitude is win/win or win/neutral; win/lose is not an option
2. Patient first, organization and individual second and third, respectively
3. Key drivers are access, service, quality, safety and patient satisfaction
4. Eliminating barriers is the operational mandate
5. Mission, vision, and values are all known, well-defined, and aligned among constituents

# Aligned Partners

6. Delivery mechanism processes are seamless to patients
7. No surprises based communications among constituents
8. Success is defined by incremental volume growth and margin
9. Venture outlives any original member
10. Business plans/program drive revenue and margins; financial reporting is only a “report card” on organizational/program performance



# Governance Options

	<u>Who</u>	<u>Physician Involvement</u>	<u>Examples of What Board Does</u>
O P T I O N S	Lay Board Only	No Physician Involvement	Formulate Policies
	Lay Board Only - Physicians as Guests	Some consultation or request for opinions	Determine Key Strategies
	Lay Board Majority – no more than 60/40 Board/Physician Members	Opinions sought out by board with active participation	Determine Market Position/Brand
	Physician Board Majority (change in corporate form)	Majority Voice	Ensure Desired Quality Outcomes
	Physician Only (change in corporate form)	Only Voice	Oversee Management
			Oversee Operational Adherence To Board policies



# Management Options

	<b><u>Structure</u></b>	<b><u>How Hospital's Interact with Physicians</u></b>	<b><u>Performance Drivers</u></b>	<b><u>Consequences</u></b>
↓ <b>P A R T N E R I N G</b> ↓	Administrative staff no physician involvement	No Involvement	No Metrics	None
	Administrative staff with some physician involvement	Little Involvement	Financial Metrics	Individual
	Service line co-management of physician and administrative staff	Departmental Interaction	Clinical Metrics	Team
	Dyadic leadership model system wide	System wide inter-dependency	Outcome Metrics	Organizational
	Physician Leadership	Partnering		



# The Point on Engagement

If you only ask opinion, you foreclose future participation then and there, Doctors often feel that once they provide you a resolution according to their opinion, it's your job to fix the problem and their involvement is no longer necessary.

It's critical how you phrase the question.

Rather than say, **“What do you think?”**

say,

**“What can we do together to pursue an objective we both agree would be in our mutual best interest?”**



# A Sample COMPACT Definition

A compact is a statement of the reciprocal obligations and mutual commitments that define the relationships among the clinicians at \_\_\_\_\_, and \_\_\_\_\_ as an organization. It is the *quid pro quo*, or the “deal” between the clinicians and the sponsoring organization. It defines what clinicians expect to get in the relationship. It is intended that this compact will help shape and drive behaviors, and in turn the overall culture of \_\_\_\_\_.

The medical clinicians and leadership of \_\_\_\_\_ will identify the selected compact statements as critical to the ongoing success of the individual and corporate clinical practices at \_\_\_\_\_, contributing to the overall success of the patient experience provided by \_\_\_\_\_.

**NOTE: Attached Exhibit: Four generations at work and tips to manage millennials**



# The Traditional Physician Compact

- The **give** (expectations)
  - **See** patients
  - **Make** good medical decisions
- The **get** (in return)
  - **Protection** (running business, market forces)
  - **Autonomy** (no patient care interference, control over preferred practice style)
  - **Entitlement** (yearly pay increases, referrals regardless of behaviors)



# The New Physician Compact

- The **give** (expectations)
  - Customer focused
  - Teamwork
  - Responsibility for problems and solutions
  - Openness to innovation
  - Delegation of authority
- The **get** (in return)
  - Influences on decisions
  - Open communication
  - Responsive management
  - Fair compensation based on the market and individual performance



# Win-Win Outcome

<b>SAMPLE COMPACT ELEMENTS</b>	
<b>SPONSORING ORGANIZATION RESPONSIBILITIES</b>	<b>INDIVIDUAL PHYSICIAN RESPONSIBILITIES</b>
<b>QUALITY</b>	
<ul style="list-style-type: none"><li>• Recruit and train superior physicians and staff</li><li>• Support career development and professional satisfaction</li><li>• Acknowledge contributions to patient care and the organization</li><li>• Create opportunities to participate in or support research</li><li>• Create an environment that supports teams and individuals</li><li>• Provide direction for developing, measuring, analyzing and reporting performance improvement activities</li></ul>	<ul style="list-style-type: none"><li>• Practice state-of-the-art, quality medicine</li><li>• Encourage patient involvement in care and treatment decisions</li><li>• Achieve and maintain optimal patient access</li><li>• Insist on seamless service</li><li>• Implement "X system" clinical standards of care</li><li>• Participate in and support group and governance decisions</li><li>• Proactively adapting to change, controlling change and effecting change</li><li>• Embrace innovation and continuous improvement</li></ul>



# Win-Win Outcome

<b>SAMPLE COMPACT ELEMENTS</b>	
<b>SPONSORING ORGANIZATION RESPONSIBILITIES</b>	<b>INDIVIDUAL PHYSICIAN RESPONSIBILITIES</b>
<b>COMMUNICATION</b>	
<ul style="list-style-type: none"><li>• Share information regarding strategic intent, organizational priorities, and business decisions</li><li>• Offer opportunities for constructive dialogue</li><li>• Provide regular, written evaluation and feedback</li></ul>	<ul style="list-style-type: none"><li>• Communicate clinical information in clear, timely manner</li><li>• Request information, resources needed to provide care consistent with "X system" goals</li><li>• Provide and accept feedback</li><li>• Embrace/utilize physician-to-physician communication</li></ul>



# Win-Win Outcome

<b>SAMPLE COMPACT ELEMENTS</b>	
<b>SPONSORING ORGANIZATION RESPONSIBILITIES</b>	<b>INDIVIDUAL PHYSICIAN RESPONSIBILITIES</b>
<b>PATIENT/COMMUNITY SATISFACTION</b>	
<ul style="list-style-type: none"><li>• Provide the tools needed to support the delivery of care</li><li>• Share feedback (both positive and negative) and survey results</li></ul>	<ul style="list-style-type: none"><li>• Treat all members with respect</li><li>• Demonstrate the highest levels of ethical and professional conduct</li><li>• Behave in a manner consistent with group goals</li><li>• Manage up the organization and its employees and medical staff and allied health professional staff</li></ul>



# Win-Win Outcome

<b>SAMPLE COMPACT ELEMENTS</b>	
<b>SPONSORING ORGANIZATION RESPONSIBILITIES</b>	<b>INDIVIDUAL PHYSICIAN RESPONSIBILITIES</b>
<b>LEARNING</b>	
<ul style="list-style-type: none"><li>• Support and facilitate teaching, GME, and CME</li><li>• Provide information and tools necessary to improve practice</li></ul>	<ul style="list-style-type: none"><li>• Participate in or support teaching</li><li>• Receptive to implementing the latest advancements in medicine</li></ul>

# Cultural Options

- Alignment of your culture with new strategy and structure will be important
- Integration of multiple cultures
  - Hospital Board
  - Employed Physicians
  - Management Turnover
  - Independent Physicians
- How does everyone want to be treated?
- What would a new culture look and feel?



# Cultural Transformation

Working Definition:

1. The shared set of beliefs, values, customs and behaviors of a set of people or an organization as viewed from both the outside and the inside.
2. Leaders impact culture and culture impacts leaders. (e.g. Leadership  $\longleftrightarrow$  Culture)

<u>Heritage and Traditions</u>	<u>Language and Symbols</u>	<u>Shared Values</u>	<u>Service Theme</u>	<u>Service Guidelines</u>	<u>Service Standards</u>
Hospital Centric					
OR	OR	OR	OR	OR	OR
Physician Centric					
OR	OR	OR	OR	OR	OR
Patient Centric: <b>Mutually Determined</b>					



# Sample Design Outline Organizational Authority & Decision Making Matrix

## DEFINITIONS

- Excepting only the reserved powers described in the bylaws, either the Board or a yet to be formed Hospital/Clinic "Parent" has authority over all affairs. This authority matrix is an instrument by which the Board delegates authority from time to time.
- The function of the matrix is not to limit the authority of the Board, but rather to clarify which authority the Board has chosen to retain and which to delegate, to whom and to what extent.
- **Final approval (A)** means that while the delegation is in effect, the entity with final authority may act autonomously (e.g., not subject to any higher approval).
- **Design approval (DA)** shall mean the obligation to initiate, prepare, and/or present for approval policies, standards, processes, and plans, and then continuously to evaluate results and to modify the policies, standards, processes, or plans. Design authority differs from autonomy in that:
  - An obligation to initiate exists; one may not choose to do nothing.
  - All plans and actions remain subject to final approval of the Board.
- **Review/recommend authority (R/R)** shall mean that policies, standards, and plans shall be developed using the policy development/problem-solving (Attachment A - SBAR) form, at the initiation of the Board, administration, or other Board-designated task force or committee, through consultation with the reviewing entity. The reviewing entity (e.g., Board of Directors or Parent Board) retains perpetually the obligation for evaluating results and recommending changes.
- **Input/Influence (I)** – Individual opinion of either process or outcome with strong preference(s) stated.

## LEGEND:

- I = Input/Influence; organization seeks it
- DA = Design Approval
- A = Final Approval
- R/R = Review/Recommend (use SBAR template)
- X = Not Applicable

## INSTRUCTIONS:

- For each item,
- Select only one level of involvement for:  
R/R = Review/Recommend, A = Final Approval, and DA = Design Approval
- Select all levels that may apply for: I = Input System Report, and  
I = Influence Individual Report

- I. (TYPICAL) CORPORATE RESERVE POWERS
- II. ORGANIZATIONAL/STRATEGIC
- III. CLINICAL OPERATIONS
- IV. CLINICAL MODEL(S) - PRACTICE
- V. CLINICAL MODEL - INPATIENT
- IV. CLINICAL MODEL - SERVICE LINES/INTEGRATED SERVICES (e.g. Ancillaries)

## -CONSTITUENCIES-

	IDS/Parent Board	Board Committees (as needed)	Operations Council	Corporate Board	System Executive Team	Medical Group (group as a whole)	Medical Group Administrator/Leadership	Individual Provider (Physician or Mid-Level Practitioner)
I. (TYPICAL) CORPORATE RESERVE POWERS								
II. ORGANIZATIONAL/STRATEGIC								
III. CLINICAL OPERATIONS								
IV. CLINICAL MODEL(S) - PRACTICE								
V. CLINICAL MODEL - INPATIENT								
IV. CLINICAL MODEL - SERVICE LINES/INTEGRATED SERVICES (e.g. Ancillaries)								



# Attachment A - SBAR Form

## SBAR

(A Problem Solving and Policy Development Tool)

### **Situation -**

Description of difficulties/concerns of current state

### **Background -**

Describe causes of difficulties/concerns and pertinent information to the situation (who has the problem, why, and to what extent)

### **Assessment**

Qualitative and quantitative analysis regarding the situation (one or two sentences)



# SBAR Form

## **Recommendations**

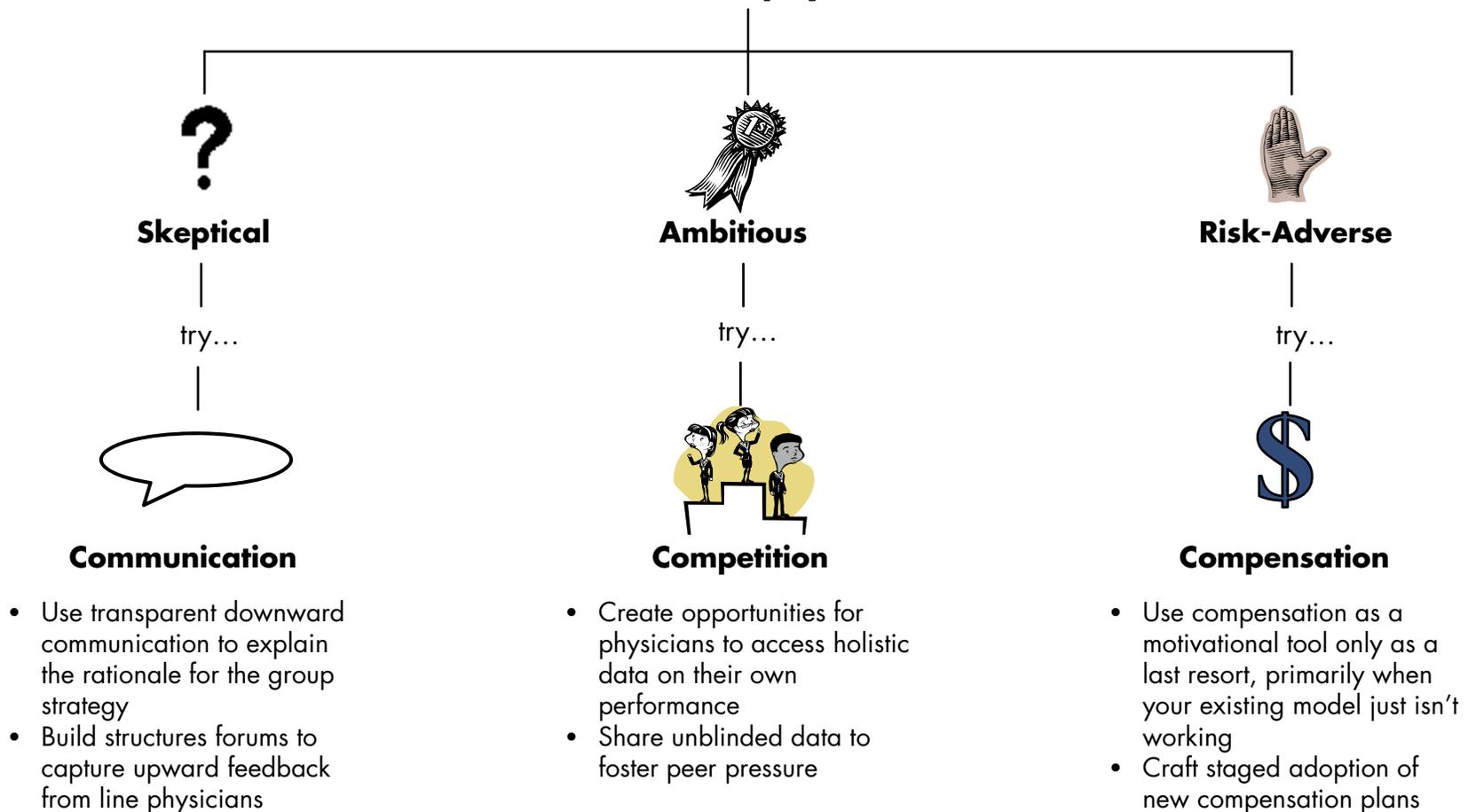
1. List possible alternative solutions (including doing nothing) and impact of each if implemented
2. Identify best solution (from alternatives listed above) to be implemented
3. Explain justification for the best solution chosen
  - a. Method of implementation:
    - i. Process
    - ii. Timeline
    - iii. Identify person(s) responsible
    - iv. Physician's role(s)
  - b. State expected results when implementation is complete – who are impacted and how will it affect them?
  - c. Describe monitoring process to ensure original problem was solved. (If original problem was not solved, complete process again starting with Situation: Description of difficulties/concerns.)
    - i. Process
    - ii. Person(s) responsible
    - iii. Physician's role(s)



# Having Trouble Tailoring Your Message?

Use the “Three Cs” to Deliver the Right Message to the Right Physician

**I need to motivate a physician who is...**



- Use transparent downward communication to explain the rationale for the group strategy
- Build structures forums to capture upward feedback from line physicians

- Create opportunities for physicians to access holistic data on their own performance
- Share unblinded data to foster peer pressure

- Use compensation as a motivational tool only as a last resort, primarily when your existing model just isn't working
- Craft staged adoption of new compensation plans



# Sample – Range of Decision-Making Performance

## 1. Presenter/Chair makes decision and announces it.

- Presenter completes the entire problem-solving process (e.g., SBAR); defines the problem, determines alternative solutions, selects solution and implements it.
- Announces decision to the Clinic Leadership Council (for example)
- May or may not consult team members for advice or agreement.
- Coercion may or may not be used or implied.

## 2. Presenter/Chair sells decision.

- Presenter takes responsibility for completing the policy development/problem-solving processes, and then arrives at decision to be implemented.
- Persuades council members to accept decision.
- When faced with resistance, seeks reduction of it by explaining what each facet of opinion has to gain from the decision.

## 3. Presenter/Chair presents ideas and invites questions.

- Presenter arrives at decision and seeks acceptance of ideas through "give and take" process.
- Clinic Leadership Council is better able to understand what presenter is trying to accomplish through question and answer sessions.
- "Give and take" enables presenter and council members to more fully explore the implications of the decision; decision closure is achieved.



# Sample – Range of Decision-Making Performance

4. Presenter/Chair presents tentative decision; however, it is subject to change.
  - Presenter identifies and defines problem coming to a tentative solution.
  - Tentative solution is taken to the Clinic Leadership Council for their discussion and influence on the final decision.
  - Before finalizing decision, presenter presents proposed solution for the reaction of all who will be affected by it.
  - Chair asks for frank reactions but notes he/she will reserve final decision.
5. Presenter/Chair presents problems, gets suggestions, and then makes decisions.
  - This time, presenter does not have a tentative solution to problem for discussion by board/committee.
  - Council members get first chance to suggest solution. Presenter's initial role involves identifying the problem and requesting physicians to suggest solutions to problem identification.
  - The council's function becomes one of the increasing presenters' repertory of possible solutions to the problem with the purpose being to capitalize on the knowledge and experience of those who are on the "firing line."
  - After receiving an expanded list of alternatives, the leader then selects a solution that she/he regards as most promising.

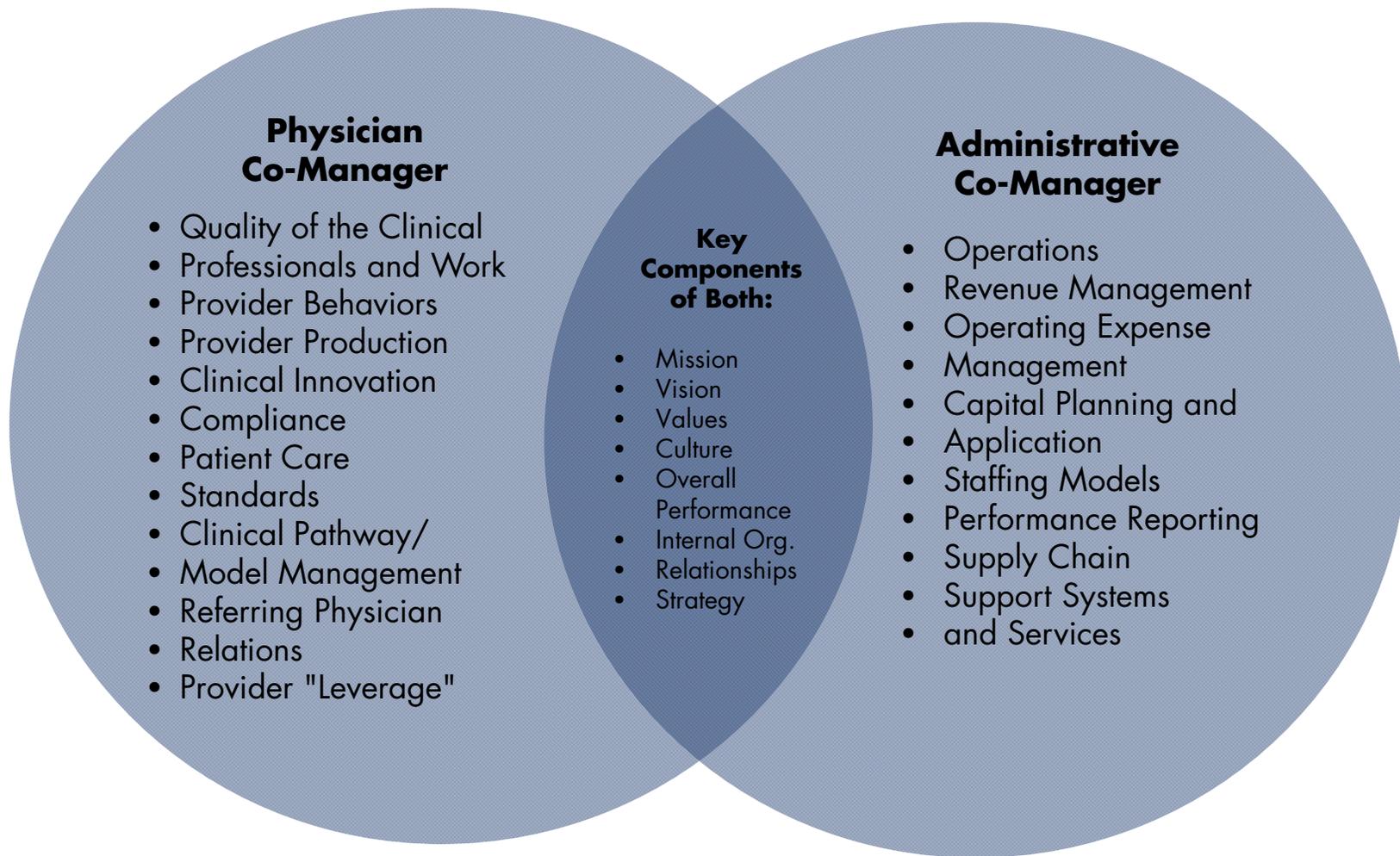


# Sample – Range of Decision-Making Performance

6. Presenter/Chair defines the limits and requests the council to make a decision.
  - At this point the chair passes to the group (with himself/herself as a member) the right to make decisions.
  - The chair defines problem to be solved and the boundaries within which the decision must be made.
  - The group makes the decision and chair/presenter coordinates the implementation among group members, including himself/herself.
7. The Chair permits the group to make decisions within prescribed limits. This represents an extreme degree of Council freedom only occasionally encountered in formal organizations.
  - The team of clinicians/C-Suite representatives as a group undertakes identification and diagnosis of the problem, develops alternative procedures for solving them and decides on one or more of the alternative solutions for implementation.
  - If the chair participates in this process, he/she does so with no more authority than any other member of the Council. The chair is committed in advance to assist with whatever decision the council makes.



# The Dyadic Management Model for Service Lines or Fully Integrated Systems



Source: Examining the "Dyad" as a Management Model in Integrated Health Systems, Daniel K. Zismer, PhD, and James Brueggemann, MD, January 2010



# What do Physician Clinical Service Line Co-Managers Do

1. Clinical service line component assignments; the staffing of programs and weekly physician assignments.
2. On-call schedules and performance.
3. Referring physicians relations.
4. Monitoring, evaluation and reporting of quality and service results. s.
5. Works with managers (and other physicians) on:
  - Bed occupancy management
  - Efficiency of capital intensive clinical areas (cath labs, OR's)
  - Drug formularies
  - Implantable device selection/use
  - Application and use & extenders
6. Work with colleagues on practice style variation; trend to "best practice"
7. Participates in provider recruiting
8. New clinical program development (including development of program leaders)
9. Effective use of consultants.
10. Analysis of quality of care results (and distribution).
11. In-service training for staff.
12. Introduction and management of process efficiencies.

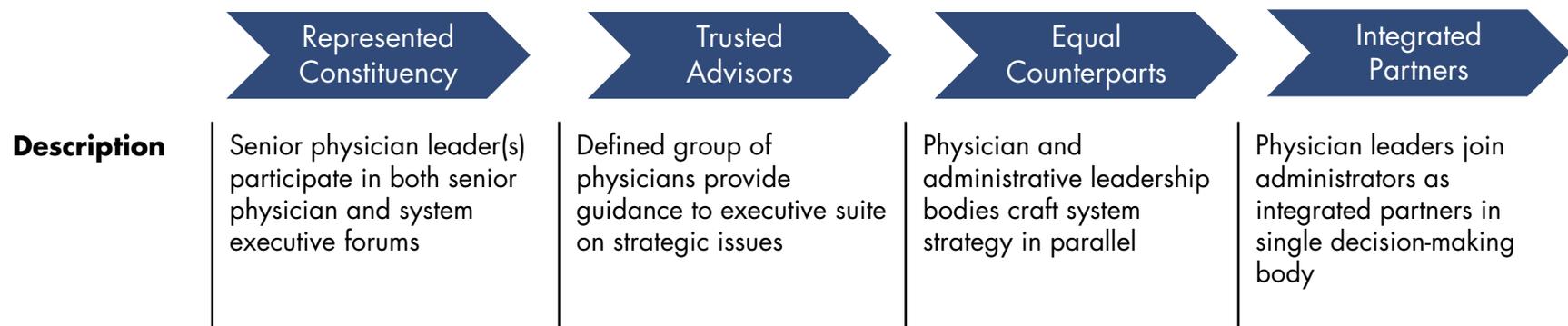


# Main Traits Successful Physician Leaders Tend to Share

1. Strong problem solving and decision-making skills
2. Emotional intelligence
3. Ability to learn quickly
4. Adaptability
5. Patience and persistence to deal with organizational change
6. Strong communication skills
7. Humility to recognize they can't do it all themselves
8. Willingness to take risks
9. Focus on results and relationships

# Physician Influence

- Four models for integrating physicians into strategic and operational planning, all of which allow for different levels of physician decision-making power.
- Provider organizations striving to increase physician engagement should ask themselves two questions when considering these options:
  1. Are current physician governance arrangements as far to the right as feasible?
  2. What is needed to migrate farther to the right **TOWARD PARTNERSHIP?**





# Physician Influence (cont.)

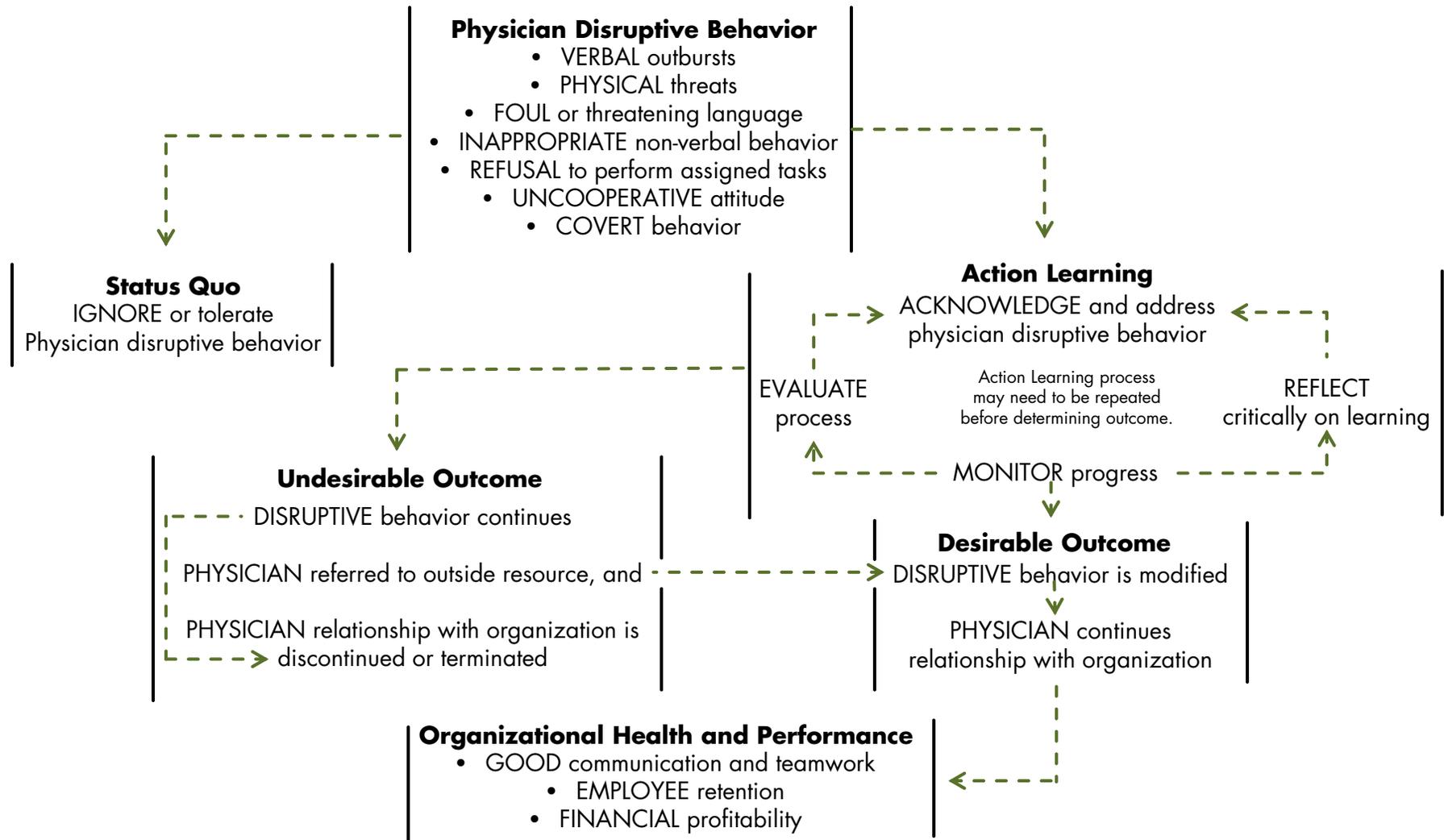
	Represented Constituency	Trusted Advisors	Equal Counterparts	Integrated Partners
<b>Description</b>	Senior physician leader(s) participate in both senior physician and system executive forums	Defined group of physicians provide guidance to executive suite on strategic issues	Physician and administrative leadership bodies craft system strategy in parallel	Physician leaders join administrators as integrated partners in single decision-making body
<b>Strengths</b>	Allows alignment of system, physician strategy through a single channel.	Creates direct feedback loop with physicians throughout strategy-setting process	Physician voice cannot be overlooked, ignored	Enmeshes physician, administrative priorities from the outset
<b>Weaknesses</b>	Does not enfranchise physicians as equals in setting strategy; does not lend a representative voice to multiple physician constituencies	Denies physician formal decision-making power; physicians may feel sidelined	Potential to create “us vs. them” power struggles between administration and physicians; may produce redundant strategic planning efforts	Potential for conflict, stalemate if physician, administrative priorities cannot be reconciled
<b>Advisory Board Assessment</b>	Success contingent on having right individual in seat who is a respected physician, system leader	Incorporates physician contribution without granting formal power, but widespread recognition of physician role in strategy key to success	Provides physicians with formal power in setting strategy; separate bodies may delay consensus on final strategic direction	Provides most efficient process; strong physician-executive relationships a prerequisite

## Physician Decision-Making Power

Source: Advisory Board Survey Solutions – Physician Engagement



# Physician Disruptive Behavior Model



Source: "Disruptive Doctors " by Melanie Sullivan, EdD, MBA, *Minnesota Physician*, February 2013 (©Sullivan Physician Disruptive Behavior Model)



# Characteristics of Effective IDSs of the Future

The Essential Hospitals Institute identified seven characteristics of an effective integrated health care delivery system of the future:

- 1. Value-driven governance and leadership:** The delivery system's governing body and administrative leadership are committed to and focused on achieving the benefits of integration. Organizational structure supports integration. Strategic, financial and operational planning toward integration is clear. Data are transparent throughout the organization and to the community.
- 2. Hospital/physician alignment:** IDSs engage health care providers in developing an integrated model. For example, organizations incorporate feedback from medical providers when making administrative decisions. Clinicians and administrators also work together to make many decisions.
- 3. Financial integration:** IDSs are well prepared to assume risk-based payments. With payers, supported by staff, resources and IT infrastructure, they are able to manage contractual relationships.



# Characteristics of IDSs (cont.)

The Essential Hospitals Institute identified seven characteristics of a fully integrated health care delivery system:

- 4. Clinical integration/care coordination:** IDSs provide a full range of services in their own facilities or on an outsourced or contracted basis. Care transitions and handoffs in IDSs are effectively managed between settings, a result of strong collaborative relationships and accountability among teams and other stakeholders.
- 5. Information continuity:** IDSs utilize electronic health records to track patient visits and health outcomes, and these records are accessible to providers within and outside the system.
- 6. Patient-centered and population health-focused:** IDSs align their resources with needs of the patient population and provide significant support through social services and convenient access to care. Nearly all staff in IDSs are trained in cultural and behavioral competencies to better serve patients.
- 7. Continuous quality improvement and innovation:** IDSs foster an environment that encourages professional growth and empowers employees to innovate. Strategic activities are often tested through pilot projects, and medical providers employ evidenced-based practices.



# The 15 Skills: How to be a Great Leader

- **Know the Way: (Strategy)**

Great leaders have foresight, the ability to see a preferable future-state. They're able to plot a course toward that vision and manage the inevitable obstacles that pop up along the journey.

- Define your destination (Vision of the future)
- Chart your course (Clarity)
- Be ready to adjust your course (Entrepreneurial spirit)
- Become chief problem solver (Confronting issues)
- Embrace change and track your progress (Managing change)



## The 15 Skills: How to be a Great Leader (cont.)

- **Go the Way: (Business Results)**

Great leaders have the ability to prioritize, execute and achieve business results, regardless of the difficulty, risk, or personal hardship involved.

- Be an expert (Business acumen)
- Innovate (Driving innovation)
- Get things done (Achieving results)
- Exercise good judgment (Sound judgment)
- Know your customers (Client focus)



## The 15 Skills: How to be a Great Leader (cont.)

- **Show the Way: (Employee Engagement)**

Great leaders build great teams, inspire them, connect them and earn their trust.

- Build a great crew (Building teams)
- Inspire them (Inspiring others)
- Earn their trust (Interpersonal communications)
- Break down walls (Collaborating)
- Care. Really, truly give a hoot. (Valuing talent)



# Building a Culture of Trust: Board, CEO, Physicians

- *Enthusiastic Engagement*
  - Seats at Board-level strategic planning
  - “Open book” on statistics and money
  - Council/committee policy participation
- *Insightful Investments*
  - State-of-art technology; well-trained staff with known performance standards
  - Role in capital allocation process
  - Projects link to patient care
- *Communication*
  - Two way; consistent, fair, frequent
  - “No surprises” information flow
  - Available Board interaction on critical issues
  - Social events/collegiality
  - **SERVANT LEADERSHIP** attitude: How can I help you to be optimally successful for mutual benefit?

# Questions?



This presentation is presented with the understanding that the information contained does not constitute legal, accounting or other professional advice. It is not intended to be responsive to any individual situation or concerns, as the contents of this presentation are intended for general informational purposes only. Viewers are urged not to act upon the information contained in this presentation without first consulting competent legal, accounting or other professional advice regarding implications of a particular factual situation. Questions and additional information can be submitted to your Eide Bailly representative, or to the presenter of this session.



CPAs & BUSINESS ADVISORS



## **Perry R. Hanson, MHA**

Director, Health Care Organizational  
Development Consulting

Eide Bailly LLP

Ph: 612.253.6697 (office)

Ph: 612.619.0399 (mobile)

[phanson@eidebailly.com](mailto:phanson@eidebailly.com)



CPAs & BUSINESS ADVISORS

[www.eidebailly.com](http://www.eidebailly.com)



# Exhibit: Four Generations at Work

- The Silents: 1925 – 1949
- The Boomers: 1943 – 1960
- Generation X: 1961 – 1981
- Millennial Generation: 1982 – 2000

# Types of Generations

- Adaptive (Silents) – Born 1925-1949
  - Overprotected and suffocated youths during a secular crisis
- Idealist (Boomers) – Born 1943-1960
  - Increasingly indulged youths after a secular crisis
- Reactive (Gen X'ers) – Born 1961-1981
  - Grow up under-protected and criticized youths during a spiritual awakening
- Civic (Millennials) – Born 1982-2000
  - Increasingly protected as children after a spiritual awakening



# When Generations Collide:

**“So much of what is going on in our lives is seen through our own generational lens.”**

- For the first time in U.S. history, we have four separate generations working side-by-side.
- While there is no magic birthday date that makes a member of a specific generation, one's experience and sharing of history helps shape a “generational personality” during their formative years.

When generational collisions occur, the results are:

- Reduced profitability
- Hiring challenges
- Increased turnover rates
- Decreased morale



# How Generations Differ

- Social, Political, & Economic Influences
- Family Structure & Influence
- Education
- Values/Morals
- Work Ethic
- Preferred Leadership Approach
- Communication Style
- Motivational Buttons
- Interaction with Others
- Preferred Approach to Feedback
- View towards Company
- Work vs. Personal Life
- Desired Rewards
- Financial Behaviors
- Relationship with Technology
- General Expectations



# Personal and Lifestyle Characteristics by Generation

	Veterans (1922-1945)	Baby Boomers (1946-1964)	Generation X (1965-1981)	Generation Y (1981-2000)
Core Values	<ul style="list-style-type: none"> <li>• Respect for authority</li> <li>• Conformers</li> <li>• Discipline</li> </ul>	<ul style="list-style-type: none"> <li>• Optimism</li> <li>• Involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Skepticism</li> <li>• Fun</li> <li>• Informality</li> </ul>	<ul style="list-style-type: none"> <li>• Realism</li> <li>• Confidence</li> <li>• Extreme fun</li> <li>• Social</li> </ul>
Family	<ul style="list-style-type: none"> <li>• Traditional</li> <li>• Nuclear</li> </ul>	<ul style="list-style-type: none"> <li>• Disintegrating</li> </ul>	<ul style="list-style-type: none"> <li>• Latch-key kids</li> </ul>	<ul style="list-style-type: none"> <li>• Merged families</li> </ul>
Education	<ul style="list-style-type: none"> <li>• A dream</li> </ul>	<ul style="list-style-type: none"> <li>• A birthright</li> </ul>	<ul style="list-style-type: none"> <li>• A way to get there</li> </ul>	<ul style="list-style-type: none"> <li>• An incredible expense</li> </ul>
Commercial Media	<ul style="list-style-type: none"> <li>• Rotary phones</li> <li>• One-on-one</li> <li>• Write a memo</li> </ul>	<ul style="list-style-type: none"> <li>• Touch-tone phones</li> <li>• Call me anytime</li> </ul>	<ul style="list-style-type: none"> <li>• Cell phones</li> <li>• Call me only at work</li> </ul>	<ul style="list-style-type: none"> <li>• Internet</li> <li>• Picture phones</li> <li>• E-mail</li> </ul>
Dealing with Money	<ul style="list-style-type: none"> <li>• Put it away</li> <li>• Pay cash</li> </ul>	<ul style="list-style-type: none"> <li>• Buy now, pay later</li> </ul>	<ul style="list-style-type: none"> <li>• Cautious</li> <li>• Conservative</li> <li>• Save, save, save</li> </ul>	<ul style="list-style-type: none"> <li>• Earn to spend</li> </ul>
Work Ethic and Values	<ul style="list-style-type: none"> <li>• Hard work</li> <li>• Respect authority</li> <li>• Sacrifice</li> <li>• Duty before fun</li> <li>• Adhere to rules</li> </ul>	<ul style="list-style-type: none"> <li>• Workaholics</li> <li>• Work efficiently</li> <li>• Crusading causes</li> <li>• Personal fulfillment</li> <li>• Desire quality</li> <li>• Question authority</li> </ul>	<ul style="list-style-type: none"> <li>• Eliminate the task</li> <li>• Self-reliance</li> <li>• Want structure and direction</li> <li>• Skeptical</li> </ul>	<ul style="list-style-type: none"> <li>• What's next</li> <li>• Multitasking</li> <li>• Tenacity</li> <li>• Entrepreneurial</li> <li>• Tolerant</li> <li>• Goal oriented</li> </ul>

Chart copyright: Hammill, Greg. "Mixing and Managing Four Generations of Employees. FDU Magazine Online. Winter/Spring '05



# Personal and Lifestyle Characteristics by Generation (cont.)

	Veterans (1922-1945)	Baby Boomers (1946-1964)	Generation X (1965-1981)	Generation Y (1981-2000)
Work is...	<ul style="list-style-type: none"> <li>An obligation</li> </ul>	<ul style="list-style-type: none"> <li>An exciting adventure</li> </ul>	<ul style="list-style-type: none"> <li>A difficult challenge</li> <li>A contract</li> </ul>	<ul style="list-style-type: none"> <li>A means to an end</li> <li>Fulfillment</li> </ul>
Leadership Style	<ul style="list-style-type: none"> <li>Directive</li> <li>Command-and-control</li> </ul>	<ul style="list-style-type: none"> <li>Consensual</li> <li>Collegial</li> </ul>	<ul style="list-style-type: none"> <li>Everyone is the same</li> <li>Challenge others</li> <li>Ask why</li> </ul>	<ul style="list-style-type: none"> <li>*TBD</li> </ul>
Interactive Style	<ul style="list-style-type: none"> <li>Individual</li> </ul>	<ul style="list-style-type: none"> <li>Team player</li> <li>Loves to have meetings</li> </ul>	<ul style="list-style-type: none"> <li>Entrepreneur</li> </ul>	<ul style="list-style-type: none"> <li>Participative</li> </ul>
Communications	<ul style="list-style-type: none"> <li>Formal</li> <li>Memo</li> </ul>	<ul style="list-style-type: none"> <li>In person</li> </ul>	<ul style="list-style-type: none"> <li>Direct</li> <li>Immediate</li> </ul>	<ul style="list-style-type: none"> <li>E-mail</li> <li>Voice mail</li> </ul>
Feedback and Rewards	<ul style="list-style-type: none"> <li>No news is good news</li> <li>Satisfaction in a job well done</li> </ul>	<ul style="list-style-type: none"> <li>Don't appreciate it</li> <li>Money</li> <li>Title recognition</li> </ul>	<ul style="list-style-type: none"> <li>Sorry to interrupt, but how am I doing?</li> <li>Freedom is the best reward.</li> </ul>	<ul style="list-style-type: none"> <li>Whenever I want it, at the push of a button</li> <li>Meaningful work</li> </ul>
Messages that Motivate	<ul style="list-style-type: none"> <li>Tour experience is respected</li> </ul>	<ul style="list-style-type: none"> <li>You are valued.</li> <li>You are needed.</li> </ul>	<ul style="list-style-type: none"> <li>Do it your way.</li> <li>Forget the rules.</li> </ul>	<ul style="list-style-type: none"> <li>You will work with other bright, creative people.</li> </ul>
Work and Family Life	<ul style="list-style-type: none"> <li>Ne'er the twain shall meet</li> </ul>	<ul style="list-style-type: none"> <li>No balance</li> <li>Work to live</li> </ul>	<ul style="list-style-type: none"> <li>Balance</li> </ul>	<ul style="list-style-type: none"> <li>Balance</li> </ul>

Chart copyright: Hammill, Greg. "Mixing and Managing Four Generations of Employees. FDU Magazine Online. Winter/Spring '05



# Comparing the Generations

	Silents	Baby Boomers	Generation X'ers	Millennials
<b>Traits</b>	Patriotic; loyal; heads down; onward and upward; polite; fiscally conservative; faith in institutions; high work ethic; graciousness; work experience; may feel overlooked and underappreciated; "I've acquired wisdom over the years but there doesn't seem to be much demand for it."	Idealistic and optimistic; highly competitive; overwhelming need to succeed; question authority; divorce; death of parent; kids in college; may be turning inward; difficulty admitting something is wrong; don't like to ask for help; experienced; team-workers;	Eclectic; resourceful; comfortable with change; self-reliant; adaptable' skeptical about relationships and distrust institutions; high divorce rate; info-highway pioneers; full of energy; fun at work; the generation that "got rid of the box"	AKA "the Digital Generation"; globally concerned; integrated; cyber literate; media and technology savvy' expect 24-hour info; realistic; probably have too much stuff to sort through; acknowledge diversity and expect others to do so too; environmentally conscious; will try anything
<b>Negative Stereotypes</b>	Can't use technology; refuse to give up the reins; non-engaged	Materialistic; work hard not smart; sold out their ideals; heavily in debt; not loyal	Haven't paid their dues; too young for management; say what they think; slackers; aggressive; annoying; loud	Unaware of lack of skills; require excessive affirmation; MTV generation
<b>Values</b>	Job stability; long-term careers; great reputation; fiscally responsible; take care of possessions and responsibilities	Who am I? Where did my passion go? Is it too late to get it back? Seek organizations with integrity; politically correct; eager to put their own stamp on things; good pay; community involvement	Be my own boss; team environment contrasted with entrepreneurial spirit; advancement opportunity	High value on education; high value on life style balance; work is not the most important thing; stepping stone for future opportunities; high tech, innovative; diverse workforce; be my own boss
<b>Recruitment, engagement, management and retention</b>	Recognize their loyalty and experience; select activities that help them show what they know; remember that traditionalists have career paths tool; focus on evolution, not revolution	Be aware of Boomers' competitive nature; acknowledge their contributions; focus on how they can make an impact; offer continued training opportunities especially life skills and balance.	Respect their skepticism; establish your credentials; show you have a sense of humor; let them know you like them; talk about how training applies to their careers, not just their jobs	Don't assume they are all at the same level in training; expect to do more remedial training; teach in shorter modules, testing often and making it fun; help them visualize how the training applies to their jobs; understand they learn best by collaborating

Source: Lancaster, Lynne C. When Generations Collide: How to Solve Generational Puzzle at Work. The Management Forum Series. 2004.



# Comparing the Generations (cont.)

	Silents	Baby Boomers	Generation X'ers	Millennials
<b>The workplace as an institution</b>	40% say their companies don't do a good job at making them want to stay; 70% think a one-company career is good; 48% say training opportunities play a role in staying; 73% plan to return to work in some capacity after they retire	43% say they lack mentoring opportunities and 30% say that contributes to job dissatisfaction; 75% say time off would be the greatest reward; 35% think a one-company career is good; prone to workplace burnout	30% have left a job due to a lack of training opportunities; 80% of Gen X'er men put time with family above challenging work or a higher salary; only 17% think a one-company career is good	Globally aware, cyber literate, techno-savvy, personal safety is #1 workplace issue; they expect diversity
<b>Improving Feedback and communication</b>	"No news is good news." May not be sending enough info down the ladder, nor receptive to info coming up the ladder; provide training in feedback skills (50% haven't received feedback training); assume they can change behaviors	"Once a year, formal and documented." Initiate weekly informal talks and formally document them	"So how am I doing?" Give feedback all the time and to the point: be available; allow freedom to keep them learning and focused on career paths; immediate and regular feedback; tell it like it is (X'ers have a well-turned BS-ometer)	"I want it with the push of a button. Let's all talk about it." Initiate the connection; consider electronic connection and newsletter; make it visual; allow them an active role in creating their own education and work plans
<b>Performance Rewards</b>	Seek high-performing traditionalists and mix them with high potential Xers to transfer the learning; to consider alternative scheduling or job sharing; recruit them actively; make them feel part of the culture' help them ease in to retirement; recognize the satisfaction of a job well done	Money, title, recognition; recognize them as the first 'sandwiched' generation caring for children as well as parents; provide time off with pay; provide life skills and balance training; provide second-career avenues	X'ers have shaken up the rewards system; skeptical about jobs and organizations; prefer time with family and outside interests; provide opportunities for development of personal and professional life.	Providing work that has meaning

Source: Lancaster, Lynne C. When Generations Collide: How to Solve Generational Puzzle at Work. The Management Forum Series. 2004.



# Comparing the Generations (cont.)

	<b>Silents</b>	<b>Baby Boomers</b>	<b>Generation X'ers</b>	<b>Millennials</b>
<b>Birth Years</b>	1928-1946	1946-1964	1965-1981	1982-2000
<b>Population size</b>	59 million	80 million	50 million	76 million
<b>Influencers</b>	The Great Depression, World War II, the GI Bill, the Cold War	Booming birthrate; economic prosperity; Vietnam; Watergate; Protests and human rights movements; sex, drugs and rock'n'roll; suburbia; dual incomes	Sesame Street and MTV; personal computers; children of divorce; AIDS' crack cocaine' loss of 'world' safety	Expansion of technology and media; drugs and gangs; pervasive violence; widening chasm between haves and have-nots; unprecedented immigration growth
<b>View of Institution</b>	Loyal to institution	Want to put their stamp on institution	Are skeptical of institution	Judge institutions on their own merit
<b>#1 reason for staying on the job, or for changing jobs</b>	Loyal to their clients and/or customers	Making a difference	Building a career	Work that has meaning

Source: Lancaster, Lynne C. When Generations Collide: How to Solve Generational Puzzle at Work. The Management Forum Series. 2004.



# Effective Messages

**To Silents:** “Your experience is respected,” or “It is valuable to hear what has worked in the past.”

**To Boomers:** “You are valuable, worthy,” or “Your contribution is unique and important to our success.”

**To Gen X'ers:** “Let’s explore some options outside of the box,” or “Your technical expertise is a big asset.”

**To Millennials:** “You will be collaborating with other bright and creative people,” or “You have really rescued this situation with your commitment.”

Source: Lancaster, Lynne C. When Generations Collide: How to Solve Generational Puzzle at Work. The Management Forum Series. 2004.



# Tips for Millennial Management

- Provide structure.
  - Monthly due dates.
  - Jobs have fairly regular hours.
  - Certain activities are scheduled every day.
  - Meetings have agendas and minutes.
  - Goals are clearly stated and progress is assessed.
  - Define assignments and success factors.
- Provide leadership and guidance.
  - Millennials want to look up to you, learn from you, and receive daily feedback from you.
  - They want “in” on the whole picture and to know the scoop.
  - Plan to spend a lot of time teaching and coaching and be aware of this commitment to millennials when you hire them. They deserve and want you very best investment of time in their success.



# Tips for Millennial Management (cont.)

- Encourage the millennial's self assuredness, "can-do" attitude, and positive personal self-image.
  - Millennials are ready to take on the world.
  - Their parents told them they can do it – they can.
  - Encourage – don't squash them or contain them.
- Take advantage of the millennial's comfort level with teams. Encourage them to join.
  - They are used to working in groups and teams.
  - In contrast to the lone ranger attitude of earlier generations, millennials actually believe a team can accomplish more and better – they've experienced team success.
  - Millennials gather in groups and play on teams; you can also mentor, coach and train your millennials as a team.



# Tips for Millennial Management (cont.)

- Listen to the millennial employee.
  - Your millennial employees are used to loving parents who have scheduled their lives around the activities and events of their children.
  - These young adults have ideas and opinions, and don't take kindly to having their thoughts ignored.
  - After all, they had the best listening, most child-centric audience in history.
- Millennial employees are up for a challenge and change.
  - Boring is bad.
  - They seek ever-changing tasks within their work.
  - What's happening next is their mantra.



## Tips for Millennial Management (cont.)

- Millennial employees are multi-taskers on a scale you've never seen before.
  - Multiple tasks don't phase them.
  - Talk on the phone while doing email and answering multiple instant messages – yes!
  - This is a way of life. In fact, without many different tasks and goals to pursue within the week, the millennials will likely experience boredom.
- Take advantage of your millennial employee's computer, cell phone and electronic literacy.
  - Are you a Boomer or even an early Gen-Xer? The electronic capabilities of these employees are amazing.
  - The world is wide, if not yet deep, for your millennial employees.



# Tips for Millennial Management (cont.)

- Capitalize on the millennial's affinity for networking.
  - Not just comfortable with teams and group activities, your millennial employee likes to network around the world electronically. Keep this in mind because they are able to post their resume electronically as well on Web job boards viewed by millions of employers. Sought after employees, they are loyal, but they keep their options open – always.
- Provide a life-work balanced workplace.
  - Your millennials are used to cramming their lives with multiple activities.
  - They work hard, but they are not into the sixty hour work weeks defined by the Baby Boomers.
  - Home, family, spending time with the children and families, are priorities.
  - Balance and multiple activities are important to these millennial employees.



# Tips for Millennial Management (cont.)

- Provide a fun, employee-centered workplace.
  - Millennials want to enjoy their work; they want to enjoy their workplace.
  - They want to make friends in their workplace.
  - Worry if your millennial employees aren't laughing, going out with workplace friends for lunch, and helping plan the next company event or committee.
  - Help your long-term employees make room for the millennials.



# Tips for Millennial Management - Conclusion

Millennials view the world and using that knowledge to motivate them in a way that works. Here's a hint: meet them where they are and they will achieve your underlying goals; **try to force them to fit your definitions and they will run for the door every time.**